FORM 152

The Commonwealth of Massachusetts
Department of Industrial Accidents
600 Washington Street – 7th Floor, Boston Massachusetts 02111
Info. Line (800) 323-3249 ext. 470 in Mass. Outside Mass. - (617) 727-4900 ext. 470
http://www.mass.gov/dia

AMENDMENT/SUSPENSION OR CLOSURE OF VOCATIONAL REHABILITATION PLAN

Check One: **AMENDMENT** ☐ **SUSPENSION** ☐ **CLOSURE** ☐

Employee (Please Print): _____ DIA Board #: _____

Street Address: _____

City, State, Zip: _____

Adjuster: _____ Tel. Number: _____

VR Provider: _____

Address: _____

VR Specialist: _____ Tel. Number: _____

Vocational Goal: _____ DOT Code: _____

Complete the following if you are AMENDING OR SUSPENDING the VR plan:

1. Reason for Amendment/Suspension: _____

_____

_____

2. Proposed Amendment to Plan (attach other sheet if needed): _____

_____

_____

3. Additional VR Services and costs that are required:

SERVICES	FROM	TO	ESTIMATED COST
_____	_____	_____	$_____
_____	_____	_____	$_____

SIGNATURES

Employee's Signature: _____ Date: _____

Print Employee's Name: _____

VR Specialist: _____ Date: _____

Insurer's Rep.: _____ Date: _____

OEVR Rehab Review Officer: _____ Date: _____

OVER

Complete the following if you are CLOSING the Rehabilitation Plan:

Complete the following if the employee is working:

_____ Returned to Work with same employer, modified job.

_____ Returned to Work with same employer, different job.

_____ Returned to Work with different employer, similar job.

_____ Returned to Work with different employer, different job.

_____ Retrained, Returned to Work with same employer.

_____ Retrained, Returned to Work with different employer.

If employer is different from former employer, please complete the following:

Employer Name: _____

Address: _____

_____

Return to Work Date: _____ Hourly Wage $_____ AWW $_____

Has Employee been continuously employed for 60 days: **Yes** ☐ **No** ☐

Occupational Title: _____ DOT Code: _____

VR Provider Expenses (voc. Testing, TSA, C & G, etc.): $_____

Other VR expenses (tuition, fees, B/S, transportation, etc.): $_____

Total VR Costs: $_____

REASON FOR CLOSURE (check all that apply): **CLOSURE DATE:** _____

1. _____ Medical condition precludes rehabilitation
2. _____ Not likely to benefit from further rehabilitation
3. _____ RTW on own accord prior to finalized IWRP
4. _____ Retired or deceased
5. _____ IWRP services completed w/o RTW - Plan expired
6. _____ IWRP services completed: rehabilitation successful
7. _____ Employee is Relocating
8. _____ Non-cooperation.
9. _____ Other (explain) _____

_____

_____

Note: Upon completion of form, please sign on the front!